# PRIVACY and CONSENT DISCLOSURE

I authorize Deanna J. Anderson, DDS and associates at Anderson General Dentistry & Implants to perform diagnostic procedures, such as, x-rays, study models, photographs or any other form of diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I authorize the dental staff to perform any dental service as may be necessary for proper dental care with my informed consent.

I authorize and consent to the disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I understand that I may withdraw or revoke this consent in writing. Any revocation would not pertain to information already used or disclosed prior receipt of written withdrawal.

**ACKNOWLEDEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I, _____, acknowledge that I have been offered a copy of the Notice of Privacy Practices (available upon request) from the above named practice.

# OFFICE and FINANCIAL POLICY

**BROKEN APPOINTMENTS***: Should a cancellation occur with less than 48 hours notice not including weekends we reserve the right to apply a $50 broken appointment fee.* Excessive broken appointments without appropriate notice will result in pre-payment with credit card to secure an appointment or dismissal from the practice. Please help us serve you and our other patients by keeping your scheduled appointment or providing sufficient notice.

**INSURANCE**: Please remember your insurance policy is a contract between you, your employer and your insurance company. Our relationship is with you and not your insurance company. ***Please understand we will provide an estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated.*** Upon request, we can submit a pre-determination request to your insurance plan, this is an estimate provided by your insurance company and not a guarantee of payment. Anderson General Dentistry & Implants is not responsible for denials or alternative allowances your plan may determine after services are rendered**.** ***Any balance is your responsibility whether or not your insurance company pays any portion.***

**PAYMENT IS DUE AT TIME OF SERVICE**: FULL PAYMENT is due at time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service.**

We accept payments in the form of Cash, Check, Visa, Mastercard, Discover, American Express and Care Credit. We offer some no interest options with Care Credit, apply at www.carecredit.com . We also work with Proceed Finance as another financing option.

**MINORS ACCOMPANIED BY AN ADULT**: Payment or co-payment is expected from the parent accompanying the child to the appointment. Parents/Guardians are expected to remain in the reception area during treatment and will not be permitted in the treatment rooms. This allows us to focus on your child and their dental needs.

*I confirm that I have read, understand and agree to all of the above terms and conditions of Anderson General Dentistry & Implants. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.*

Signature_____ (patient or guardian) Date_____